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ABSTRACT

This paper begins with a discussion of need, followed by a description of two types of sex education programs for alcohol counselors. The first program described is a single two-hour lecture and discussion which is offered as part of a series of presentations in a basic educational program. The second is a 10-session, 20-hour workshop for professional counselors who are already working with alcoholics. The theoretical framework for both programs is presented, along with a description of their content, including information on the effects of alcohol on sexual functioning. (Author)

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Sex Education for Alcohol Counselors

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SEX EDUCATION FOR ALCOHOL COUNSELORS

ROBERT O. HAWKINS, JR.

Introduction

Why sex education for alcohol counselors? Basically for two reasons: 1) alcoholics have sexual concerns and problems, and 2) few alcohol counselors have the knowledge or skills necessary to help the alcoholic with those concerns, even on a basic, elementary level. The conspiracy of silence is alive and well! This paper describes two types of sex education programs for alcohol counselors: the first, a single two-hour lecture and discussion which is part of a series of presentations in a basic educational program for prospective alcohol counselors, and the second, a ten-session, twenty-hour workshop for professional counselors working with alcoholics.

Sufficient evidence exists in the literature to support the concept that any sex education program for people in the helping professions must include an attitudinal as well as an informational component. Researchers and educators such as Lief and Ebert,[1] Young,[2] Gochros,[3] and Vacalis[4] identify the attitudinal component as being the most important, because it is often the professional's attitude which will determine whether or not the client expresses any need for the professional's knowledge. Six years of personal experience in teaching courses and delivering workshops on various topics in sexuality has demonstrated that students and participants are generally resistant to an attitudinally focused approach. Instead, they express a desire for factual information. One may postulate reasons for this; however, regardless of the reasons one should be aware that the resistance exists. In addition, if the program is not voluntary, one can also expect an occasional attitude of, "I know all about sex, what do I need this for?" Or as one alcohol counselor said at the beginning, "Why are we having this workshop? None of

my clients have sexual problems!" Thus the beginning of any program should clarify for the participants that: a) there is something factual for them to learn, b) sexual concerns do exist in their clients, and c) the attitude of the professional toward sexuality is not only a valid issue to explore but indeed, a vital one.

Single lecture, discussion

Any single lecture on the topic of sexuality should begin with the theoretical framework on which the lecturer bases her or his approach, and the components of that framework should be amplified by examples. For this presentation, there are three basic components: 1) sexual behavior is learned; 2) any particular sex act is neutral; and 3) the sex counselor must be nonjudgmental, both verbally and nonverbally. It should be further understood that one's sexual attractions and repulsions are the result of a complex set of factors, none of which can be isolated; and while psychosexual development is a bio-socio-psychologically determined phenomenon, the sociological and psychological components far outweigh the biological. Also, no judgments about any specific sexual activity can or should be made simply because an act occurs. Instead one must look at other factors such as the participants and their values, the setting, and the interactions. In addition, in sex counseling the professional should avoid using such terms as normal, natural, abnormal, or unnatural. Instead, emphasis should be on what is psychologically healthy and unhealthy for the person involved. In order to accomplish this, the professional must have a high level of self-awareness concerning sexual attitudes, and must be able to receive information from the client without initially passing judgment on that information.

The reluctance of health professionals to explore the sexual concerns of their clients' needs to be understood. Two issues seem to be readily apparent. First, is a hesitancy which arises because the professional is aware of his or her lack of factual knowledge, and should

a question arise, the answer might have to be, "I don't know, but I'll find out for you." This means possibly exposing one's ignorance on sexual matters not only to the client but also to oneself. Second, is a feeling of helplessness which arises from a perceived lack of skill in helping someone who presents with a sexual concern or problem. There is a feeling of, "If my client does express sexual concerns and problems, what am I going to do about it?" To address both of these concerns, the presentation should provide a short bibliography for the participants to use as reference texts, and also should provide a list of referral sources.

However, the alcohol counselor must be made aware that it is more important to allow the sexual concerns to be expressed than it is to keep them hidden simply because the professional does not know the answer or how to handle the problem. No one can expect to be an expert in all things and we understand this concept in most instances. Yet when the issue is sexuality, many of us feel to protect our professional image we are "supposed" to know all about it and know also how to take care of any problems that arise. Notice the irony. There is an expectation for expertise and yet one wonders how many programs for the training of alcohol counselors contain any information on human sexuality.

Another reason for the lack of exploration of sexual concern is the client's perception of the professional as judgmental. This may exhibit itself in the tone of voice, facial expressions, or body movement, or it may simply be that the client believes that what she or he has done is so terrible that condemnation would follow from anyone who hears about it. Using the ubiquitous questioning technique suggested by Richard Green[5] is helpful in overcoming many of the clients' concerns. For example, rather than ask, "Do you have any sexual problems," begin by saying, "Many alcoholics experience sexual problems or just have questions about sexual matters and I was wondering what problems or questions you have?"

To emphasize the fact that the counselors need factual information, they can be asked to silently answer a few simple true-false questions. For example, the person giving the presentation may say the following: "True or False. Primates reared in isolation do not know how to engage in coitus. If you answered false, with the knowledge that sexual functioning for primates is biologically determined and that coitus is innate behavior, then you missed the question. The statement is true." Then go on to discuss the necessity for primates to engage in rehearsal play while young and to observe adult coital behavior in order to successfully copulate. The need for sexual discussions with alcoholics can be shown by citing research on sexual dysfunction and alcohol, self-esteem in alcoholics, or communication problems in alcoholic couples. However, the factual information on specific physiological effects should begin to alert the counselors to the fact that this is an important issue for exploration with the client.

Before giving the specific information on the effects of alcohol on sexual function, one should discuss the issues which confound diagnosis of the etiology of any problem. Those issues are: 1) alcoholics and non-alcoholics have some identical sexual problems and it may be difficult if not impossible to determine how much of the effect is directly attributable to the consumption of alcohol; 2) people in the society, including the counselors, often evaluate sexual behavior on a stereotypic, mythological basis; and 3) sexual concerns and/or problems may be a precipitating factor for excessive drinking. For example, Gallant[6] cites two situations in which the increased alcohol consumption was a result of opposite initial outcomes. In one case, sexual success occurred after drinking and the male made an association which said that the alcohol was responsible for the success and continued his alcohol consumption. Another male failed in his attempt to be sexually active while drinking, and rather than see the alcohol as causative, questioned his own masculinity,

thereby increasing anxiety and insuring failure the next time. This set up a cycle in which, to avoid failure, he avoided sexual activity, creating further questioning of his masculinity and increasing alcohol consumption.

The next section of the presentation should list specific effects of alcohol on sexual functioning. This should be preceded by the caution that the statements are generalized and should be understood as such. For example, alcohol is a depressant and anesthetic. Physiologically, therefore, every male active alcoholic should experience erectile dysfunction. The fact is that this is not the case. Female spouses of alcoholics who participated in a family education program in Nassau County, New York, reported that some male alcoholics experience erectile dysfunction but certainly all of them do not.[7]

What are the specific effects of alcohol on sexual functioning?

1. Small doses of alcohol may affect the consumer according to the person's expectancy set.[8]

2. With increased consumption, the penile and clitoral nerves become anesthetized, with extent dependent on amount of alcohol consumed, and orgasmic potential is lessened.[9]

3. If there is liver damage in the male, testosterone will be metabolized at five times its normal rate,[10] and in the male, there will be a lessened ability to metabolize estrogen, thereby causing development of secondary female sex characteristics.[11,12]

4. The enzyme which produces Vitamin A and is therefore responsible for sperm production has a propensity for metabolizing alcohol; consequently, sperm production will be lowered and testicular atrophy may result.[13]

5. Nerve damage is possible and if extensive, could affect erectile potential in the male and female.[14]

6. Lubrication in the female may be lessened.[15]

7. Female alcoholics report that they feel more "feminine" while drinking.[16]

8. Communication between partners is lessened.[17]

In addition, alcoholic females report a larger incidence of incestual relationships than is reported for the general population. In fact, it appears more appropriate to ask a female alcoholic, "How frequently were you engaged in a sexual relationship with your parents or siblings?" than "Have you ever been involved in an incestual relationship?"

The counselor must also be aware of sexual concerns during early sobriety. This requires a determination of the sexual expectations of both the alcoholic and his or her partner. Often, the alcoholic may have an expectation that if sexual activity (read "intercourse") could occur successfully, then everything will be all right. Should he or she have that expectation, there is a high probability that the guilt, anxiety, and anger often present during early sobriety will interfere with any attempts for sexual interaction and the person will experience further anxiety. This should be discussed with the alcoholic and the alcoholic's partner. Sexual activity during early sobriety, in many cases, should begin with an approach similar to sensate focus, allowing the couple to build up positive interactions without the pressure for performance and/or orgasm. It will also be necessary to assess the sexual activity which occurred prior to and during the period of active alcoholism, to determine how knowledge of these activities is being processed by both the alcoholic and his/her partner, including the impact on present expectations.

To give the counselors an exercise in "nonjudgmentalism," add a discussion of incest, pointing out the little acknowledged possibility than an incestual relationship need not always be negative, that sexual arousal brought on by one's children is not necessarily evil, adding that one does not have to act on one's arousal. Counseling may have to focus on the guilt brought about by an incestual relationship that was pleasant, or in instances

where the experience was not pleasant, giving the client permission to express dislike for the other participant. Unlike popular concepts, there is no unwritten or written universal law that says one must love one's parents or siblings.

Another concern which has arisen recently is the assumption on the part of the counselor that if the client's sexual orientation is homosexual, then she or he would prefer to attend a gay AA group. While that may be true for some, others validly feel that they have no need to additionally focus on homosexuality, and indeed, for some, their orientation is not a relevant issue.

Allowing for the participants to ask questions or make comments will help to validate many of the issues in this presentation, particularly if there are recovered alcoholics among the counselors.

Workshop

The following is a description of a workshop designed for alcohol counselors with an overall goal of increasing the awareness of the counselor with regard to sexuality and alcoholism. Specific objectives are:

To enable the alcohol counselor to:

- develop an awareness of the range of human sexual behavior
- discuss sexual behavior in a nonjudgmental atmosphere
- assess the level of personal feelings about various sexual behaviors
- impart factual sexual information to clients
- identify sexual concerns of clients
- identify possible need for referrals for sex counseling and/or therapy

The sessions are divided into didactic, discussion, and experiential segments to provide the participants with the opportunity to obtain factual information, be aware of personal reactions,

and improve skills indealing withthe sexual concerns of those whom they serve.

There are nine two-hour sessions, given once each week, with one follow-up session given three months after the ninth session. There is a test of factual information and an attitude assessment which is given at the beginning of the workshop and again at the three-month follow-up session. In addition, the participants are asked to comment on the extent to which the workshop objectives were met, and to identify any need for additional training.

There were from 20 to 32 participants at each session, with 11 participants, six male, five female, who attended all of the sessions. The mean age of the group of 11 was 47.5 ranging from 27 to 71 years, with a standard deviation of 11.8. No one had taken a course dealing with human sexuality prior to this workshop, five were high school graduates, three had bachelor's degrees, two master's degrees, and one Ph.D. Two-thirds of the group were recovered alcoholics. Two were not married, one had been married for one month, and the remainder had been married an average of 26 years. Their early religious training they identified as "strict to moderate" and described their present religiosity as "liberal to none." In comparison to college juniors and graduate students, they were older, and had been married longer. On a pre-test of sexual knowledge they were one standard deviation below the mean for graduate students in a beginning sex education course.

The workshop design was an adaption of the National Sex Forum's Sexual Attitude Restructuring Process (SAR), with an added focus on alcohol and sexuality. All of the information and concerns expressed in the description of the single lecture, discussion sessions were included at various points throughout the workshop. The nine sessions were designed to begin with basic information on sexuality, using the pre-test as a guide; then add an exposure to variations in sexual expressions, then issues in general sex counseling, followed by counseling with complications of alcohol, and finally, to allow the participants to

determine future needs for themselves and the departments in which they work.

Specifically the nine sessions were:

1) an introductory session which included an explanation of objectives, a pre-test, and a discussion of sexual myths and sources of sex education for the participants;

2) desensitization, using sexually explicit films covering heterosexual, homosexual, and bisexual activity, masturbation, and sexual activity for the physically handicapped and aging, followed by a discussion of participant attitudes about viewing the films; all designed to provide a common sexual experience to begin discussions in as non-threatening a way as possible, and to encourage use of appropriate terminology for sexual activity;

3) male sexuality, discussing male psychosexual development and sexual response cycle;

4) female sexuality, discussing female psychosexual development and sexual response cycle;

5) paraphilias, discussing some of the more common variations in sexual behavior to expose the workshop participants to a wide range of behavior;

6) specific effects of alcohol on sexual functioning;

7) sex counseling techniques using role playing with cases in which alcohol was not a confounding variable;

8) sexual counseling for problems in which alcohol was involved; and finally,

9) a brief discussion of sex therapy to enable the participants to make a reasonable judgment about the need for referral, followed by a general summary of the workshop and participant determination of what they wanted in the follow-up session;

10) the follow-up session was used to give the post-test on knowledge and attitudes; to discuss specific case histories that the counselors had encountered during the three-month period; and to ask what they saw as needs for themselves and their particular counseling unit.

Results

On the test of knowledge, with a Kuder-Richardson 20 coefficient of reliability equal to .76, the t-test significance level was $p < .10$. The small number of participants included in the statistics could account for the low level of significance. The test of attitude showed a slight shift toward a more liberally expressed viewpoint, but with no significant difference from the pre-test. While these results might be depressing to some, looking at the nature of individual shifts is important. For example, the participants generally either moved from a liberally expressed viewpoint to a more neutral one, or from a conservative toward a more liberal attitude. Both of these are viewed as positive results.

In their subjective evaluations the counselors reported a heightened awareness of possible sexual concerns in their clients, more comfort in addressing sexual issues with their clients, more personal comfort in their own sexual interactions, and a need for more information, especially in counseling regarding incest. Also, as a result of this workshop, the sponsoring department identified two individuals at each of its major units who would be responsible for sex education, and work is now underway to develop a series of lectures and group discussion formats to be used at the detoxification unit, which is a short-term, transient facility; the out-patient facility; and the rehabilitation unit, each unit in turn having increasing time with the alcoholics. There will be a basic, 20 minute lecture on the effects of alcohol on sexual functioning and this will be expanded to a full series of lectures and group discussions available for the long-term rehabilitation unit.

Conclusion

The alcohol counselor must be involved in learning about sex and sexuality and in continuing development of skills in sex counseling. Once this is accomplished, we will have more information available on the effects of alcohol on sexual functioning which will enable us

to better deliver total health care.

This paper has described a sex education workshop approach to increasing the understanding of alcohol counselors about the sexual problems of alcoholics so that they can begin to help the client in a holistic fashion, incorporating his or her sexual concerns into the counseling plan. The success of this approach has yet to be fully evaluated, but the fact that the sponsoring department has identified individuals within it to receive further training and to act as resources for the various units is certainly a beginning indicator of success.

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